

Neurologic Surveillance and Testing

through the Viral and Rickettsial Disease Laboratory at the California Department of Public Health

Physicians MUST obtain approval from NST before sending samples.**Fax this form to 916-440-5940 or email to NeuroSurveillance@cdph.ca.gov to obtain approval.****Patient Information**

Last Name _____ First Name _____ DOB ____/____/____ MR # _____

Street Address _____ City _____ Zip Code _____ County _____

Tel (____) _____ Name of surrogate decision-maker or guardian _____

Race: ☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Other ☐ Unknown Ethnicity: ☐ Hispanic ☐ Non-HispanicGender: ☐ Female ☐ Male Occupation _____**Exposure Information (preceding and within 1 month of onset)**Animal or Arthropod contact ☐ No ☐ Yes Details: _____Immunizations up to date ☐ No ☐ Yes Details: _____Immunization in last month ☐ No ☐ Yes Details: _____Medications (including OTC and herbal): ☐ No ☐ Yes Details: _____Outdoor activity (camping, hiking, gardening, etc): ☐ No ☐ Yes Details: _____

Other pertinent exposures (including day care, head trauma, sick contacts, TB exposure etc) _____

Travel 1 month before onset? Specify dates and locations☐ outside U.S. _____ ☐ in U.S. _____ ☐ in CA _____☐ Ever traveled outside the U.S.? _____**Significant Past History**Immunocompromised? ☐ No ☐ Yes If yes, please elaborate: _____Hypertension ☐ No ☐ Yes Diabetes ☐ No ☐ Yes (If yes, what type? Insulin dependent?) _____

Other PMH (medical, social, family) _____

Clinical InformationIllness onset date ____/____/____ Date of hospital admission ____/____/____ Fatal? ☐ No ☐ Yes

Discharge date ____/____/____ Discharge location _____ If fatal, date of death ____/____/____

Glasgow Coma Scale (1-15) _____In ICU ☐ No ☐ Yes Date: ____/____/____Intubated ☐ No ☐ Yes Date: ____/____/____Fever $\geq 38^0$ ☐ No ☐ Yes _____URI ☐ No ☐ Yes _____GI ☐ No ☐ Yes _____Rash ☐ No ☐ Yes _____Cardiovascular ☐ No ☐ Yes _____Severe headache ☐ No ☐ Yes _____Lethargy ☐ No ☐ Yes _____Altered Consciousness ☐ No ☐ Yes _____Confusion ☐ No ☐ Yes _____Aphasia or mutism ☐ No ☐ Yes _____Extreme irritability ☐ No ☐ Yes _____Hallucinations ☐ No ☐ Yes _____Psychosis ☐ No ☐ Yes _____Dementia ☐ No ☐ Yes _____Stiff neck ☐ No ☐ Yes _____Ataxia ☐ No ☐ Yes _____Focal neurologic ☐ No ☐ Yes _____Muscle weakness ☐ No ☐ Yes _____Cranial nerve abn ☐ No ☐ Yes _____Seizures ☐ No ☐ Yes _____Intractable? ☐ No ☐ Yes _____Induced coma? ☐ No ☐ Yes Date: ____/____/____Coma ☐ No ☐ Yes Date: ____/____/____Autonomic Instability ☐ No ☐ Yes _____Movement Disorder ☐ No ☐ Yes _____Abnormal Reflexes ☐ No ☐ Yes _____Hypersalivation ☐ No ☐ Yes _____

Laboratory Results**CSF Results**

Date ____/____/____ OP ____ RBC ____ WBC ____ Diff ____/____/____/____ Protein ____ Glucose ____ VDRL ____
 seg/lymph/mono/eos

Date ____/____/____ OP ____ RBC ____ WBC ____ Diff ____/____/____/____ Protein ____ Glucose ____ VDRL ____
 seg/lymph/mono/eos

Was HSV PCR on CSF performed at hospital/commercial lab? ☐ No ☐ Yes Result: ☐ NEG ☐ POS

CBC Results

Date ____/____/____ WBC ____ Diff ____/____/____/____ HCT ____ Hb ____ Platelets ____ Glucose ____
 seg/lymph/mono/eos

Date ____/____/____ WBC ____ Diff ____/____/____/____ HCT ____ Hb ____ Platelets ____ Glucose ____
 seg/lymph/mono/eos

LFT ☐ Normal ☐ Abnormal _____

ANA ☐ Normal ☐ Abnormal _____

BUN/Cr ☐ Normal ☐ Abnormal _____

CXR ☐ Normal ☐ Abnormal _____

ESR ☐ Normal ☐ Abnormal _____

Oligo bands ☐ Normal ☐ Abnormal _____

Other labs, cultures, microbiological studies, Xrays, test results: _____

Brain CT Date ____/____/____

☐ Normal ☐ Abnormal ☐ Not done

If abn: ☐ temporal lobe

☐ white matter demyelination

☐ hydrocephalus

☐ severe cerebral edema

☐ other _____

Brain MRI Date ____/____/____

☐ Normal ☐ Abnormal ☐ Not done

If abn: ☐ temporal lobe

☐ white matter demyelination

☐ hydrocephalus

☐ severe cerebral edema

☐ other _____

EEG Date ____/____/____

☐ Normal ☐ Abnormal ☐ Not done

If abn: ☐ diffuse slowing

☐ temporal epileptiform activity

☐ PLEDS

☐ other _____

Treatment

Antiviral agents _____

Date Started ____/____/____

Antibacterial agents _____

Date Started ____/____/____

Steroids? ☐ No ☐ Yes _____ Date Started ____/____/____ **IVIG?** ☐ No ☐ Yes Date Started ____/____/____

Physician/Hospital Contacts

*** **REQUIRED – FOR RESULTS & FOLLOW-UP** ***

Treating Physician Name _____ Pager (____) _____ Email _____

Primary Physician Name _____ Pager (____) _____ Email _____

FACILITY _____

FAX (for sending results) (____) _____ **Alternative FAX** (____) _____

REQUIRED STEPS FOR SUBMITTING SAMPLES:

1. Physicians must obtain approval from NST **prior to** submission of samples. See instructions or website <http://www.cdph.ca.gov/programs/vrdl/Pages/NeurologicSurveillanceTesting.aspx> for more information.

2. Send ALL required samples (CSF, acute serum, NP/Th swab) with Case History Form and Specimen Submittal Form to:
 Attn: Specimen Receiving, 850 Marina Bay Parkway, Richmond, CA 94804

3. Notify your local public health department of all cases submitted for testing.

Specimens will not be tested unless all 3 requirements have been met. Call 510-620-3777 with questions about NST.